COMMUNICATIONS SUPPORT FOR HEALTH (CSH) PROGRAMME

GOVERNMENT OF THE REPUBLIC OF ZAMBIA CAPACITY ASSESSMENT REPORT

DECEMBER 2014

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Contents

Introduction

The main objective of the United States Agency for International Development–funded Communications Support for Health (CSH) project is to strengthen the capacity of the Government of the Republic of Zambia's (GRZ) Ministry of Community Development, Mother and Child Health (MCDMCH); National Malaria Control Centre (NMCC); and National HIV/AIDS/STI/TB Council (NAC) to develop and implement evidence-based information, exchange, communication (IEC) and behaviour change communication (BCC) interventions.

At the start of the project in 2010, CSH conducted a baseline assessment of GRZ's capacity to manage effective IEC/BCC activities. The assessment revealed both strengths and weaknesses in GRZ's capacity related to the development and effective implementation of IEC/BCC interventions. To track improvements in the different GRZ institutions' capacity over the life of the project, CSH conducted annual capacity assessments that assessed the technical capacity of each of the institutions in three main areas: planning and design of IEC/BCC activities, IEC/BCC programme implementation, and monitoring and evaluation (M&E) of IEC/BCC activities. After each of the assessments, CSH recommend areas for improvement. To further document and capture how GRZ's capacity to manage effective IEC/BCC activities has changed over the life of the project, CSH conducted a final comprehensive capacity assessment that drew from the results of the annual capacity assessments and also included a qualitative assessment to understand how effective CSH's technical support has been in building GRZ's capacity.

Objectives of the Assessment

The main objective is to conduct a comprehensive capacity assessment of the three GRZ institutions that work in IEC/BCC health-related activities (MCDMCH, NAC, and NMCC) in order to understand and document the changes in GRZ's capacity to manage effective IEC/BCC activities and to determine the effect of CSH's technical support in strengthening this capacity.

Specifically, the main objectives of the assessment are to

1. Assess the perceived changes in GRZ's capacity to design, implement, manage, and monitor and evaluate IEC/BCC activities over the life of the project and how these changes in capacity have affected the quality of IEC/BCC activities implemented by each of the three GRZ institutions.
2. Assess the effectiveness of CSH's technical support and capacity-building strategies in strengthening the capacity of GRZ to manage effective IEC/BCC activities.
3. Determine what, if any, existing gaps there are in the capacity for each of the GRZ entities (MMCDMCH , NAC and NMCC) to manage effective IEC/BCC activities, and provide recommendations moving forward on how those gaps could be filled.

Methodology

Overview of the Capacity Assessment Index

The Behaviour Change Programming (BCP) Capacity Assessment Index was developed by the CSH project. The index is a tool for assessing the capacity of an institution to plan, implement, monitor, and evaluate BCC interventions and programmes. The index provides an overall score (out of 100) and summary scores for each of the following specific capacity areas: BCC planning and design, programme implementation, and M&E. The results from the assessment are tracked within CSH's Performance Monitoring and Evaluation Plan. The assessment is administered annually.

There are 10 key capacity domains in the capacity assessment, grouped within three main categories:

1. **BCC Planning and Design**
   - Health problem definition and situational assessment
   - Conduct of behavioural analysis
   - Programme definition and communication strategy development
   - Detailed communication planning
   - Establishment of strategic partnerships
2. **BCC Programme Implementation**
   - Implementation of communication strategies
   - Staff capacity
   - Supervision and quality of BCC intervention delivery
3. **BCC Monitoring and Evaluation**
   - M&E frameworks and systems
   - Data use

CSH M&E Unit staff administered the BCP Capacity Assessment Index tool in workshop settings to staff within each of the targeted institutions—MCDMCH Health Promotion Unit; NMCC BCC, Research, and M&E units; and NAC BCC Unit. A CSH programme officer embedded at NMCC also participated because only three of six NMCC staff members were available to participate in the assessment. The assessment tool was projected on a wall using an LCD projector so that all staff could read through the assessment items together. Facilitators asked probing questions, took notes, and recorded the notes and scores.

The assessment process was interactive and driven by staff responses to the individual items in the assessment tool. For each item in the assessment, staff were asked to give a score that they felt reflected their capacity to conduct the specific task, and to provide a justification for the score they gave. The staff then engaged in a discussion for each item until they agreed on a score. A CSH staff member recorded the discussions for onward translation, and another CSH staff member recorded the scores on a computer projected on a wall.

The tool was administered to the staff in a group setting to ensure that the group's responses represented the views of the institution and not those of the individual participants. This proved to be the most effective way of obtaining sufficient information from the participants. Assessors were provided with some documentation from the institutions during the assessments, while other documents were provided to the assessors after the assessments for further reference and review.

Although the assessment and timelines are linearly indicated, the actual process was iterative and mainly driven by ideas as they developed from one stage to another. In addition, the process was accompanied by the verification of documents which might have been reported on by participants in the assessment. The assessment was administered at Crossroads Lounge in Lusaka for NMCC staff on 3 April 2013, at NAC Headquarters on 15 January 2014, and at MCDMCH on 7 February 2014. Each assessment lasted approximately three hours.

The baseline Capacity Assessment Index tool for the Government Health Promotion Unit was administered in 2012, when the unit was under the Ministry of Health (MOH). However, in 2013, the GRZ undertook realignment of its ministries. In this undertaking, the Health Promotion Unit, which was then under MOH, was moved to be within the new ministry, MCDMCH. Staff who worked in this unit when it was still under MOH were also moved to MCDMCH. Therefore, the realignment of ministries did not result in any notable staffing issues.

Key Informant Interviews

In October and November 2014, CSH conducted in-depth interviews with key members within each of the three GRZ institutions—MCDMCH, NAC, and NMCC—that work in IEC/BCC activities. Specifically, the interviews targeted key IEC/BCC technical staff, M&E staff, and key directors within each of the units that oversee IEC/BCC activities.

A semi-structured interview guide was used to facilitate the interviews, which took approximately 30 minutes each (see Annex 1 for the interview guide). The results from the key informant (KI) interviews were triangulated with the annual capacity assessment results (and recommendations put forth from the assessments) and the initial baseline assessment to document the changes in capacity of GRZ over the life of the CSH project, assess the overall effectiveness of CSH technical support in building GRZ capacity, and bring out any perceived gaps that still exist in GRZ capacity to manage effective IEC/BCC activities.

Findings

Findings are presented separately for each of the institutions. Each section first presents the capacity assessment scores at baseline and endline. For each of theunits we present an overview of the scores for each of the three main categories—BCC Planning and Design, BCC Programme Implementation, and BCC Monitoring and Evaluation—as well as the components of each category. We then discuss each of the three main sections evaluated in the capacity assessment. Data from the qualitative interviews are integrated to supplement, enhance, complement or, in a few cases, provide alternative perspectives from the capacity assessment findings. Challenges, recommendations, and conclusions summarised from the three institutions are presented collectively.

MCDMCH Findings

The results from the 2014 capacity assessment show a notable improvement in the capacity of the Health Promotion Unit to plan, implement, and manage BCC interventions. The overall Capacity Assessment Index rose from 53 percent in 2012 to 59 percent in 2014. Interviews with key informants from MCDMCH also noted that they saw improvement in the overall capacity of the Health Promotion Unit over the duration of CSH's implementation.

It is important to note that the realignment of the Health Promotion Unit from MOH to MCDMCH, which took place after the baseline, stalled the implementation of some capacity-building efforts based on recommendations from the 2012 exercise, as health promotion staff needed considerable time to fit in and stabilise at MCDMCH. These stalled efforts included additional training for staff, quality control of programme implementation, and BCC M&E systems.

MCDMCH BCC Planning and Design

In terms of BCC programme design, the average Capacity Assessment Index rose from 63 percent in 2012 to 68 percent in 2014. The greatest increase was seen in the capacity to conduct behavioural analysis, which had a 33 percent increase. There was also a 13 percent increase in the units' capacity to define their programme and their development of a communication strategy. Their capacity to define health problems and assess situations remained stagnant between 2012 and 2014. Both the capacity to build a detailed communication plan and the establishment of strategic partnerships decreased from 2012 to 2014, with 9 percent and 13 percent decreases, respectively. Table 1 summarises these results.

Table 1: MCDMCH BCC Planning and Design

BCC Planning and Design Categories	2012 Average Score (%)	2014 Average Score (%)
Health problem definition and situational assessment	63	63
Conduct of behavioural analysis	42	75
Programme definition and communication strategy development	81	94
Detailed communication planning	67	58
Establishment of strategic partnerships	63	50
Average BCC Planning and Design Score	**63**	**68**

The overall capacity of the MCDMCH Health Promotion Unit to plan and design BCC interventions slightly increased between 2012 and 2014. The capacity assessments relayed that the unit has enhanced its abilities to conduct behavioural analysis using existing research and to develop detailed BCC programmes where both the primary and the secondary audiences in their various settings, as well as their needs, are identified in order to promote implementation. KIs also noted the improvement in planning and the shift to a systematic system that includes the mobilisation of and consultation with partners. A KI acknowledged the role that CSH played in the improvement of planning:

> *I should say, in terms of planning, the capacity has improved greatly, especially with MCDMCH. They've [CSH] brought in a newness of doing things; more especially, they introduced the BCP programming. That helped a lot. And then they kind of scaled it up to all the 10 provinces in the country and most of the districts. So if you were to speak to a communicator in the health system in Zambia, at least they've been oriented with BCP programming, and that helps a great deal in terms of planning—IEC materials and processes.*

Another KI described the improvement in planning and design with CSH involvement in the following way:

> *… with the coming in of CSH to MCDMCH, it has impacted greatly in the sense that when you look at the processes—speaking specifically of IEC processes—from, say, planning, designing to probably printing and distribution, there's been a positive impact in the sense that the process of planning is kind of systematic. People don't just wake up and say I want to design materials and print them. There's great consultation and mobilisation of partners. You sit together and plan, and then go through the whole process.*

Although there was an overall improvement regarding planning and design, the capacity assessment indicated an overreliance on existing research, which presented limitations due to the information gaps in secondary data. The overreliance on secondary or existing data was attributed to financial and time limitations. According to the capacity assessment, the capacity in defining the health problem and conducting a situational assessment remained at the same level, exhibiting inconsistencies in if and when this process was done, partially due to a lack of resources.

The capacity assessment showed that there was a decrease in capacity in developing detailed communication plans between 2012 and 2014., This was likely due to the lack of systems in place to monitor communication activities and limited external data with health promotion indicators. The capacity in establishing partnerships also experienced a decrease. Capacity assessment findings also highlighted that stakeholder engagement was not at the level that the unit wanted to see. The unit called for the development of the Health Promotion Strategic Plan in order to enhance

stakeholder coordination. Established partnerships appear to have been delayed due to a lack of knowledge about the work of partners and agreements to collaborate with the unit. Although formal partnerships were delayed, KIs noted the utility in the establishment of networks with the support of CSH, namely through the technical working groups (TWGs). As one KI stated:

> *With these expanded networks, I can go to any part of Zambia, any province, and I'll be able to call upon, say, the provincial BCC committee, coordinator, which wasn't there before, so it's been a great opportunity in that sense.*

With the CSH involvement, MCDMCH improved its capacity to plan and design BCC intervention activities. The greatest improvement was seen in the capacity to conduct behavioural analysis, and there was a decrease in the capacity to establish strategic partnerships. KIs were generally very satisfied with the improvements made in BCC planning and design.

MCDMCH BCC Programme Implementation

The score for the BCC programme implementation section rose from 66 percent in 2012 to 78 percent in 2014. Yet, the only increase was in the implementation of communication strategies, which increased by 35 percent. The categories of staff capacity and supervision and quality BCC intervention delivery remained the same between 2012 and 2014. Table 2 details these scores.

Table 2: MCDMCH BCC Programme Implementation

BCC Programme Implementation Categories	2012 Average Score (%)	2014 Average Score (%)
Implementation of communication strategies	61	96
Staff capacity	75	75
Supervision and quality of BCC intervention delivery	63	63
Average BCC Programme Implementation Score	**66**	**78**

The Health Promotion Unit at MCDMCH demonstrated a significant increase of capacity in BCC programme implementation. This increase was due to the implementation of communication strategies to use multiple communication channels to deliver BCC messages and frequent pre-testing of BCC products. The unit also noted that it submitted its products to the Health Promotion TWG for review. Further, the training provided by CSH played a critical role in increasing the capacity for implementation. As one KI stated:

> *The greatest impact and support has been the BCP training programming. That one is a plus because once people are oriented in that, you have a certain way of thinking and doing things. You are just aware that certain things should be done in a certain way. So that one has been a plus.*

The assessment results illustrate that the capacity of staff and supervision of BCC intervention delivery remained at the same level as in 2012, despite the upheavals due to the realignment. The unit reported that many of the staff are undergoing formal training as part of staff development and that the need exists for additional trainings for new staff at district and provincial levels. Checklists for quality control of the implementation of interventions were available, but they need revision following the realignment. Supervisory visits to observe the implementation of interventions were also limited. Further, that assessment revealed that the unit felt that more could be done if more funds were allocated.

Yet, despite the potential for improvement, KIs expressed that great progress was seen in terms of implementation than was the case before CSH. One stated:

In terms of implementation, for me, I've been very impressive, in the sense that in the past, when we developed IEC materials, we would maybe just say leave it with procurement and stores to send them to provinces and districts. But with CSH, the process is different. You'd have a scope of work. You plan. You sit as teams and partners. You have scope of work and plan how you are going to distribute and implement the use of those IEC materials.

Overall, KIs thought that the capacity amongst staff was built and that they were now better able to implement activities due to this increased capacity. One KI stated:

… the BCP trainings that were held with a number of people—there was also capacity built in technical working groups starting from the national level and then subnational with support of CSH. Capacity has been built there because every meeting we've had, we've been able to bring on board new people that are coming, so they understand how they are supposed to conduct themselves.

KIs also discussed an increase in capacity beyond the organisational staff to other key leaders of the community who play a critical role in the implementation of BCC interventions.

It's been a success story. It's been a success story, especially for reaching out to the community. I love the way they incorporated especially the traditional leadership. They trained them to such an extent that you go to a province or a district to sensitise or to introduce a [inaudible] programme, and traditional leaders are in the forefront. And more especially, in maternal health—maternal and nutrition health—so that's a very big plus for me for CSH. So that's at community level. Coming to the professional level—the BCP programming, that's a very big plus.

The capacity assessment revealed that the only increase was in the implementation of communication strategies, whereas staff capacity and the supervision and quality of BCC intervention delivery remained stagnant. Yet, interviews with key informants from MCDMCH revealed that staff capacity did improve; however, the high turnover of employees was problematic in maintaining capacity within the unit.

MCDMCH BCC Monitoring and Evaluation

The BCC programme M&E section did not show improvement, with the average score remaining stagnant at 32 percent for both 2012 and 2014. There were no changes in the capacity to build M&E frameworks and systems of data utilisation.

Table 3: MCDMCH BCC Monitoring and Evaluation

BCC Monitoring and Evaluation Categories	2012 Average Score (%)	2014 Average Score (%)
M&E frameworks and systems	25	25
Data use	38	38
Average BCC Monitoring and Evaluation Score	**32**	**32**

According to the assessment findings, the capacity of the unit to monitor and evaluate BCC interventions remained low. During the time of the capacity assessment, there was no M&E plan for the Health Promotion Unit or an M&E plan specifically for BCC interventions and campaigns. KIs also acknowledged the shortcoming of some of the M&E initiatives:

CSH tried to—well, they've tried to kind of build a database resource. They tried their level best, but I think that we haven't kind of fully implemented. So I would love to see that built. And also systems. If you have a reserve, a database, systems of

interconnectiveness to the lower levels, the provinces and districts—and just a systematic way of storing information, retrieval and use. So that one, I'd love that, to see that happen.

The capacity assessment showed no improvement in capacity to conduct M&E activities. Interviews with KIs from MCDMCH indicated that, although inadequate resources pose challenges to being able to carry out M&E activities, they are making efforts in that regard.

> *I should say that we're a bit more aware that actually things don't happen on their own. When you start a process, you need to go back and monitor to ensure that what you set out to do is being done. And if it's not being done, you sit at the table and look at it—what can we do to improve things? So in our plans, when we sit to plan for our annual activities as a ministry, and especially as a communications department, we plan for monitoring and evaluation also. It would be good to do maybe a monthly monitoring and evaluations, but resources do not permit. Therefore, where possible, quarterly monitoring and evaluations are done.*

Another KI also indicated that MCDMCH was making progress towards M&E activities.

> *Though we started to institute general M&E tools that can be utilised in BCC/IEC, but that's something which we need to finalise. We have been able to have the first draft. We took it in the field. It was used to see how user friendly it is. Now, we are at the stage where, during this meeting, they're supposed to see how we can finalise it so that as CSH closes, we should be able to take it up and be able to utilise it so that we can effectively be able to monitor and evaluate.*

NAC Findings

NAC's overall BCC capacity assessment score increased from 56 percent in 2012 to 74 percent in 2014, which indicates an improvement in the institution's capacity to design, implement, and manage effective BCC. These improvements can be attributed to both technical and financial support that NAC has received, particularly from United States Government (USG)–funded partners.

NAC BCC Planning and Design

The overall BCC planning and design score increased by 27 percent between 2012 and 2014. There were improvements in all five categories, as presented in Table 4. The greatest increase was in NAC's ability to conduct behaviour analysis, which improved by 50 percent. There also was a large improvement in the units' capacity to define health problems and conduct a situational assessment, which increased by 37 percent. The lowest increase was in having a detailed communication plan, which had an 8 percent increase.

Table 4: NAC BCC Planning and Design

BCC Planning and Design Categories	2012 Average Score (%)	2014 Average Score (%)
Health problem definition and situational assessment	63	100
Conduct of behavioural analysis	42	92
Programme definition and communication strategy development	63	81
Detailed communication planning	67	75
Establishment of strategic partnerships	63	88
Average BCC Planning and Design Score	**60**	**87**

The capacity assessment revealed that NAC usually conducts situational assessments to better understand a health problem that the unit wishes to address through a BCC intervention. Interviews with KIs revealed improvements in the process of planning and designing. KIs stated that since receiving support from CSH, planning activities and meetings now take place regularly.

> *Initially, maybe National AIDS Council, we had some technical working groups, but looking at the support since CSH, there was a time when we had a gap of we were not meeting. One because we did not have the support to provide us with resources such as, you know, meeting places, venues, and just organising the meeting itself. But with the support from CSH we started having our quarterly meetings, and from as far as I can remember, we have met every quarter.*

KIs also felt that the BCP training exposed NAC staff to more logical and methodological ways of preparing social and behavioral change programmes. Staff members also felt that they were not better able to critique materials before they are disseminated to ensure that the materials were of high quality.

Further, staff members use existing research in designing and implementing BCC interventions. KIs stated that NAC staff members are now aware of the process that should be undertaken in the development of communication materials. KIs also stated that, prior to CSH support, all subnational materials were reviewed at the central level; it was an iterative process that often took a substantial amount of time. Now there is a TWG in each province that reviews materials, which has enabled staff to clear materials for dissemination faster and has helped with the backlog of materials in need of review.

> *Before CSH, I think most of our BCC messaging—even the development of posters for fairs, fliers, and radio programmes—they were done without the initial knowledge of how, you know, we need to come up with a programme, like for instance, a radio programme. But with the capacity that has been built in us, we can now plan and come up with a radio programme which is well-planned according to the guidelines.*

Even with the overall improvement in BCC planning and design, the capacity assessment found that, due to limited financial resources, NAC over-relies on its partners to undertake new research to generate findings to inform BCC programming. The capacity assessment also revealed that NAC has designated staff for creating and managing strategic partnerships with donors, other programme implementing partners (e.g., community-based organisations, civil society organisations, and non-governmental organisations), and the private sector. NAC has a good working relationship with its stakeholders as a coordinating institution in its areas of mandate.

NAC BCC Programme Implementation

The capacity assessment showed an overall decrease in the capacity to implement BCC activities. This was largely driven by the significant decrease (38 percent) in the supervision and quality of BCC intervention delivery. NAC attributed this decrease to budgetary limitations that affected its ability to supervise the design and implementation of BCC interventions and prevented NAC from conducting supervisory field visits to ensure that implementing partners are following NAC's BCC guidelines. There were increases in both the capacity to implement communication strategies as well as staff capacity between 2012 and 2014. These results are presented in Table 5.

Table 5: NAC BCC Programme Implementation

BCC Programme Implementation Categories	2012 Average Score (%)	2014 Average Score (%)
Implementation of communication strategies	61	93
Staff capacity	75	67
Supervision and quality of BCC intervention delivery	63	25
Average BCC Programme Implementation Score	**66**	**62**

The capacity assessment found that NAC demonstrates high capacity in BCC programme implementation, particularly in the use of multiple communication channels to deliver BCC; pre-testing of BCC products; and trainings that NAC has received from its cooperating partners, including United States Government projects such as CSH. For example, NAC staff members have been trained in BCP, formative research, and M&E for BCC campaigns. While NAC does not implement BCC activities directly, it helps coordinate these activities across partners. Thus, the quality of programme implementation depends on the technical and financial abilities of implementing partners. NAC has a checklist for conducting supervisory visits to ensure that partners follow the implementation guidelines and standards for BCC activities. However, operationalisation of the supervisory tool to ensure that the BCC activities are of high quality is a challenge due to limited financial resources.

Initially, NAC and CSH only planned to train communications staff, but they realised that they also needed to train technical experts because the experts also need to understand communications materials and the process of developing them—particularly when the technical experts visit provinces and districts to collaborate with other staff members. KIs also appreciated the approach that CSH took, as one informant stated:

> *I'll talk of the training approach. I liked it in that it was so informal, very participatory, where you are going step by step. That helped, and also the issue of you train and you implement. I think that was a great idea. Because it gave us now a direct challenge to go and work on what we learned there by, even strengthen what we learned. Because others would just call you to the workshop and you do the workshop. Their approach was you are in this workshop. You learn something and then you go and implement. Because you are too sure that at the next workshop you are getting to, they would ask you what they did. And no one wants to be embarrassed. I think that approach for me was good.*

According to KIs with the support of CSH, NAC developed the National HIV/AIDS Communication and Advocacy Strategy, which contains step-by-step guidance and key messages. Interviewees stated that it has made work easier because people do not have to be technical experts to use it. For example, radio stations now air HIV/AIDS programmes after their staff were oriented on the guidelines. The impacts of the capacity built affected various aspects of the organisation. As one KI stated:

> *Because of the capacity that was built in us as a team, we came up with a strategy to be able to help programmes on TV. We have a local TV station, so we designed one. … This was to [conduct] health programmes because we realised that through the identification of programmes that we have in the response we saw that much of the data that comes from the communities and consolidated by Government is not being used. So we were like, okay, part of the reason why it is not being used is because we do not have a platform to share it. So that's how we came up with that paperwork, and an MOU [memorandum of understanding] was signed with a TV station.*

NAC BCC Monitoring and Evaluation

The M&E frameworks and systems improved by 46 percent between 2012 and 2014. Meanwhile, data use registered no improvements, primarily due to challenges in operationalisation of the NAC online reporting system, which NAC developed as a platform for implementing partners to report and share results. Table 6 details these results.

Table 6: NAC BCC Monitoring and Evaluation

BCC Monitoring and Evaluation Categories	2012 Average Score (%)	2014 Average Score (%)
M&E frameworks and systems	25	71
Data use	38	38
Average BCC Monitoring and Evaluation Score	**32**	**55**

NAC developed an online reporting system that all implementing partners are supposed to use to upload and download data and reports. However, due to funding issues, the system has not been fully operationalised, and the system cannot yet generate sufficient and accurate reports. Very few partners are inputting their performance data into the system, and the data that are collected are rarely compiled, disseminated, or shared. Further, the capacity assessment found that NAC has a well-formulated M&E plan that covers all NAC activities, but the implementation of the plan and system remains a challenge due to financial constraints. Recruiting and retaining staff in M&E positions has also been a challenge for NAC. At the time of this assessment, the M&E specialist and officer positions were both vacant—the former having been vacant since October 2013.

KIs stated that NAC staff members have not made as much progress in monitoring activities because the tools are not ready for use. For instance, a tool for tracking communication tools and their development processes has been developed and even pre-tested, but it has not been fully implemented. Yet, even with these challenges, improvements have been realised with the involvement of CSH. KIs stated that before CSH support, district-level programme officers could not identify problems or achievements. They did not even have M&E frameworks for communications, know the reasoning behind their messages, or have messages adapted for their area. Progress, however, has been made in these areas; staff members are becoming more aware and knowledgeable. They did not realise that after developing communications materials, they need to monitor the materials to see how effective they are. Now staff members are able to understand that proper communications materials can influence achievements. One KI described the changes that NAC has made, specific to M&E, since CSH involvement in the following way:

> *… on the M&E I would tell you before this programming, we had a challenge. The challenge that is there—even now if we went down to the communities—is that we have health promotion officers who face the role are not trained, who face the role who are not even there by appointment. They are just in acting positions. They're like, because we don't have this one, can we get you there? So these are technocrats who are in a different field who might have not even the knowledge of health promotion. And to worsen it, there wasn't even a framework for monitoring and evaluation. But now, so us as a team, we're privileged because one other benefit through CSH was training in M&E for communication. So now that knowledge has helped us advise these colleagues on the ground.*

Overall, KIs felt that CSH support improved the quality of NAC activities. For example, in NAC meetings staff are talking more specifically about issues, asking questions, looking at data, and basing decisions to act on data, whereas previously there was not much discussion or data use.

NMCC Findings

Overall, NMCC increased its capacity to plan, implement, and manage BCC interventions. The overall Capacity Assessment Index rose from 61 percent in 2013 to 88 percent in 2014.

NMCC BCC Planning and Design

Regarding the items specific to the capacity to plan and design BCC interventions, the average capacity rose by 17 percent, from 68 percent in 2012 to 85 percent in 2014. The highest increase was in the development of a communication plan, which increased by 25 percent. The capacity to conduct behavioural analysis and the development of a programme definition and communication strategy also saw notable increases at 20 percent and 17 percent, respectively. The lowest increase was in the establishment of strategic partnerships and health problem definition and situational assessment, at 13 percent. Table 7 presents these results.

Table 7: NMCC BCC Planning and Design

BCC Planning and Design Categories	2012 Average Score (%)	2014 Average Score (%)
Health problem definition and situational assessment	75	88
Conduct of behavioural analysis	58	75
Programme definition and communication strategy development	55	75
Detailed communication planning	75	100
Establishment of strategic partnerships	75	88
Average BCC Planning and Design Score	**68**	**85**

The capacity assessment revealed that the NMCC has stronger capacity to conduct situational assessments to better understand the health problems that they wish to address through BCC interventions. To conduct the assessments, the NMCC IEC/BCC unit uses existing research results from studies conducted by its own institution and the studies of partner organisations. Despite support from MOH research staff in most cases, the unit needs to rely on existing research to inform situational assessments due to the unit's lack of funds to conduct new research.

Staff members within the unit have received formal training in formative research as well as M&E of IEC/BCC interventions with CSH support. The capacity assessment found that the staff were able to implement and utilise the skills from the various trainings in their daily operations. A representative from NMCC who was interviewed reiterated the importance of the formative research, stating:

> *Something that comes out distinctly would be the use of results from formative research, which was very useful in guiding the development of messages and campaigns; in particular, I'm talking about the STOP Malaria campaign, which was an integrated campaign that looked at maternal health, newborn, child health, nutrition … so the use of that evidence which CSH spearheaded to help plan that.*

Furthermore, NMCC conducts periodic reviews of its IEC/BCC strategies using guidelines for developing and reviewing IEC/BCC materials that were developed with support from the CSH project. Over the past two years, the unit has collaborated with CSH to strengthen the malaria TWG, which is now reviewing NMCC IEC/BCC materials and interventions and those of partner organisations involved in implementing various malaria interventions in the country.

NMCC is a national programme that collaborates with local and national stakeholders to coordinate and/or implement malaria BCC activities. NMCC also partners with relevant organisations, including

the private sector, to implement activities, demonstrating overall high capacity in developing strategic partnerships to strengthen the implementation of its activities.

NMCC BCC Programme Implementation

There was a significant increase in NMCC's capacity to conduct BCC programme implementation from 59 percent in 2012 to 95 percent in 2014. The capacity to implement communication strategies increased by 39 percent, the staff capacity increased by 17 percent and the supervision and quality of BCC intervention delivery had the greatest increase at 50 percent. These results are summarised in Table 8.

Table 8: NMCC BCC Programme Implementation

BCC Programme Implementation Categories	2012 Average Score (%)	2014 Average Score (%)
Implementation of communication strategies	57	96
Staff capacity	83	100
Supervision and quality of BCC intervention delivery	38	88
Average BCC Programme Implementation Score	**59**	**95**

Overall, NMCC has good processes in place for defining objectives, target audiences, and appropriate communication channels for its BCC interventions. NMCC uses multiple communication channels to reach target audiences, such as radio, TV, posters, and brochures. NMCC also has good processes for developing detailed communication plans that link its activities directly to the objectives of its BCC interventions. The assessment also revealed that NMCC reported that communication activities were not always developed based on the information needs of end users, mainly due to limited financial resources. Yet, with support from CSH and other partners, in 2013 and 2014, NMCC worked on strengthening the provincial and district malaria task forces to ensure that all IEC/BCC materials and interventions designed at the national level are adapted for local or end user needs. NMCC echoed this sentiment in discussing the impact of CSH support on activities being implemented:

> *They are more focused, relevant to target audience. Some of the results from the MIS, for instance, gave us an indication in terms of the preferred choice of—the preferred communication channel for a specific target audience, so you are able to choose the channel that a certain target audience accesses. And also to mention in terms of, within realm of capacity, the development of various documents which CSH supported for the Malaria Control Programme and the MOH and I'm sure, communication development as well, the communication strategy, pre-testing guidelines, terms of reference for technical working group to ensure you're operating within specific functions. I think all those helped to make sure the capacity of not only the ministry—the two ministries—are built, but also the partners that we work with.*

KIs also mentioned that the hands-on and collaborative process that CSH implemented was key in building capacity. KIs described more innovative ways to address BCC programme implementation that were targeted for the specific audiences they were trying to reach.

> *For instance, we developed a malaria game using the concept of the snakes and ladders for school-going children, so that was a very good innovation and concept, and it has been appreciated by the MOH. So, if that can be scaled up, and because as a ministry we have be looking at ways to strengthen the health programmes in schools, and increase knowledge on various health issues amongst the school-going children, so an innovation like the game, which is entertainment and informative.*

The 2014 assessment highlighted an improvement in the staff capacity. All staff members working in IEC/BCC have received formal training in BCC. Additionally, the M&E and research officers also received formal training in M&E for BCC programmes or formative research with CSH support. The KI stated:

> *I think the other gap that we noted during the period that we were working with CSH was that we were able to build capacity in non-communication individuals, like the M&E people were able to attend the BCP training, our IT officer was also able to attend the BCP training and gained some skills. So they benefit from the programme now when I'm not around, and there's something that needs to be done, she is able to fill in.*

NMCC BCC Monitoring and Evaluation

The NMCC increased its capacity to monitor and evaluate BCC activities and interventions. Increases were seen both in the capacity to develop M&E frameworks and systems and in data use, which had 33 percent and 31 percent increases, respectively. Table 9 presents these results.

Table 9: NMCC BCC Monitoring and Evaluation

BCC Monitoring and Evaluation Categories	2012 Average Score (%)	2014 Average Score (%)
M&E frameworks and systems	46	79
Data use	44	75
Average BCC Monitoring and Evaluation Score	**45**	**77**

Supervision of BCC activity implementation by the unit remains limited due to inadequate financial resources to conduct field supervisory visits. Additionally, the staffing levels in the BCC unit do not allow for adequate supervision due to competing priorities and other activities. The NMCC worked with CSH and other collaborating partners to develop field supervisory checklists and guidelines for supportive supervision, demonstrating that standards are in place for quality supervision.

The capacity assessment found that NMCC has made progress in developing an M&E system for BCC activities, including the creation of an M&E plan that contains indicators for BCC interventions. Furthermore, NMCC is beginning to develop tools for tracking the progress of implementation and the reach of BCC interventions.

To date, however, no monitoring data on BCC interventions have been collected. Furthermore, NMCC does not have a database to capture M&E data specific to BCC interventions. Rather, it currently only captures routine clinical data through the Health Management Information System. Due to this, no data are available on BCC programme activities to inform programme management and/or improvement. As one KI stated:

> *I mentioned the four malaria indicator surveys that we did. When you look at indicators there are not enough to really give you the required information and data to guide you in better implementation of communication activities.*

Recommendations

Across all assessments, several recommendations were made to improve the process and suggestions to consider if any programmes were to be implemented after CSH. These recommendations included:

- Have funds or a budget that is specific to communications—distinct and separated from other health programming areas—and develop sustainable and ongoing streams of funding.
- Continue to build capacity, and have ongoing training and support, specifically at the

subnational level, and support the subnational TWGs with oversight, reorientations, and resources.

- Strengthen resource mobilisation and have a system in place to capture data and information that will be of utility to the specific units.
- Have ongoing trainings to specifically address the challenges of high staff turnover.
- Have any future organisations take a collaborative approach with the various units, starting from the inception and planning and throughout the implementation.
- Operationalise an M&E system for BCC interventions that will include, for example, developing the necessary data collection tools, establishing roles and responsibilities for M&E within the unit, developing a database to store and track M&E data, analysing and reviewing routine data, and using it to make adjustments or improvements to programme implementation.
- Further strengthen strategic partnerships, particularly at the subnational level, to enable adequate review of communication messages and use of evidence to define communication interventions.
- Develop and put in place quality control processes/systems for BCC activities, such as having guidelines and checklists related to observing and monitoring the quality of BCC intervention implementation.
- Ensure that guidelines and communication materials are implemented and enforced at all levels.
- Seek resources for primary data collection to bridge information gaps and inform the development of effective and evidence-based BCC programmes and interventions.
- Improve and operationalise reporting systems.
- Sensitise partner organisations on the importance of routinely inputting and using the data collected within the system for decision-making.
- Have funds for provinces to develop communications programmes with localised ideas, as well as technology to collect (recorders), analyse (computers), share data (projectors, video players), and reflect on data (digital equipment).

Conclusion

MCDMCH, NAC, and NMCC all showed significant improvements in their capacity to plan, implement, and manage BCC interventions over the course of CSH's involvement. Several partners, including CSH, implemented a series of capacity-building activities. These activities ranged from BCC trainings, to strengthening the BCC TWGs both at the central and provincial levels, to developing BCC guidelines and trainings in formative research and M&E. Although each unit continues to face challenges, as previously discussed, KIs thought that the foundation that has been established through CSH involvement will be invaluable in mitigating these challenges. KIs interviewed thought that CSH was successful in accomplishing what they set out to do—and that the consultative approach that they took was effective. All KIs enjoyed working with CSH and think that, if CSH could receive more funding, it would be beneficial to the country, more areas could be reached, and more people could be reached in areas where they were already working. The representatives from each of the ministries felt that, with the right partnerships, their respective units would be positioned to carry on the work that CSH has conducted.

Annex 1: Key Informant Interview Guide

GRZ Capacity Assessment:
In-depth Interview Guide with GRZ Staff

Good morning/afternoon. My name is _____ and I will conducting today's interview. I'm part of the research and monitoring and evaluation team of Communication Support for Health. Today, we're going to discuss how [NAC/NMCC/MCDMCH/MOH] has changed over the course of CSH providing the institution with support. We hope that this information will help us to better understand how CSH support has helped build the capacity of the institution and contributed to the development of IEC/BCC materials and activities. The findings from this discussion will also complement the findings from the institution's capacity index scores taken periodically during the time of CSH's support.
I am a trained interviewer. I want to hear your honest opinions about the topics we will discuss today. There is no right or wrong answer to the questions I'm going to ask. Please just relax and enjoy the discussion.
Please keep in mind that your participation in this discussion is completely voluntary. If for any reason you wish to leave the discussion, you may do so.
I am accompanied by_____ and who will be responsible for note taking and logistics respectively.
Before we begin, I'd like to review some rules or guidelines for today's discussion. These rules are our guidelines for operating so that we can complete our task in a manner that is respectful and provides you with the opportunity to express your thoughts safely and confidentially.

- You have been invited here to offer your experiences, views and opinions.
- Again, there are no right or wrong answers.
- It's okay to be critical. I want to hear your views and opinions about whether you like or dislike something you see or hear.
- This session will be audio taped. This allows us to capture everything that is being said today, and we will include the information in a report to our client.
- There will be observers from CSH.
- All of your answers will be confidential, so feel free to say exactly what is on your mind. Nothing will be attributed to any particular person in our report.
- You may excuse yourself from the conversation at any time for any reason.
- Lastly, please turn off the ringers on your cell phone.

Do you have any questions at this time?
Yes:_____ No:_____

I. Perceived Changes in Capacity

In the first part of our discussion, we're going to talk about how you think the capacity of [NAC/NMCC/MCDMCH/MOH] to design, implement, manage, and monitor and evaluate IEC/BCC activities has changed since CSH began providing support to the unit.

1. How has the institution's capacity to plan and design IEC/BCC activities changed since the beginning of the project?
    a. What types of processes or steps does the institution take in planning for IEC/BCC activities that it didn't before?

b. How do you think these changes in planning have impacted the quality of the institution's IEC/BCC activities?

2. How has the institution's capacity to implement IEC/BCC activities changed since the beginning of the project?
    a. What types of processes or steps does the institution take in the implementation for IEC/BCC activities that it didn't before?
    b. How do you think these changes in implementation have impacted the quality of the institution's IEC/BCC activities?

3. How has the institution's capacity to monitor and evaluate IEC/BCC activities changed since the beginning of the project?
    a. What types of processes or steps does the institution take in monitoring and evaluating IEC/BCC activities that it didn't before?
    b. How do you think these changes in monitoring and evaluation have impacted the quality of the institution's IEC/BCC activities?

4. Has the institution's capacity in other unexpected areas grown as a result of CSH's support?
    a. If so, please explain what and how these areas were improved

II. Usefulness of CSH Support

Now, we're going to discuss the usefulness of support provided by CSH in building the capacity of [NAC/NMCC/MCDMCH/MOH] to manage IEC/BCC activities.

5. What type of support from CSH did you find most effective in helping to build the institution's capacity?
    a. Trainings? Which ones?
    b. Communication strategies?
    c. M&E guidelines or frameworks?
    d. Personal technical assistance from CSH staff?
    e. Any other form of support?

6. Why were these materials or services effective in helping to build the institution's capacity?
    a. How did these directly impact the institution's capacity to manage IEC/BCC activities?

7. Which materials or services did you find to be least effective? Why?

8. What type of support do you wish CSH had provided to the institution that you think could have further helped build its capacity?

III. Remaining Gaps in IEC/BCC Capacity

Our last portion of the discussion will focus on the remaining gaps in [NAC/NMCC/MCDMCH/MOH] to manage IEC/BCC activities, and your recommendations on addressing these gaps.

9. What do you see as some of the remaining gaps in the institution's capacity to manage IEC/BCC activities? Anything specific to:
    a. Planning or designing?
    b. Implementation?
    c. Monitoring and evaluation?

10. What steps or actions do you recommend could be taken to address these gaps and continue to build capacity?
    a. What organization or institution would be best responsible or useful in carrying out these changes or actions?

IV. False Close

Please give me one moment, as I leave the room to check to see if my colleagues have any further questions.

V. Closing

[Ask any additional questions provided by the Capacity Building Team.]
Thank you for joining us today for the interview. We really appreciate your time and input.